The American Institute of Stress

HEALTH AND STRESS

Your source for science-based stress management information

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AIS provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides leadership to the world on stress related topics.

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Stress and Health is a monthly newsletter with news and advertising designed exclusively for AIS Members. However, it appeals to all those interested in the myriad and complex interrelationships between stress and health because technical jargon is avoided and it is easy to understand. Stress and Health is archived online at stress.org. Past issues can be purchased in the AIS Marketplace. Information in this publication is carefully compiled to ensure accuracy.

AIS Board of Directors

Why PTSD Stands For...

Poor Treatment from Slipshod Diagnoses

The dictionary defines fiasco as ***"A thing that is a complete failure, especially in a ludicrous or humiliating way."*** PTSD (post-traumatic stress disorder) certainly fits that description, and you could add a few other adjectives, including ***pathetic*** and ***exorbitantly expensive***. Since the term first appeared in the American Psychiatric Association's 1980 DSM-III (Third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*) it is often assumed that PTSD is a new disorder. Its purpose was to describe a set of symptoms resulting from exposure to a traumatic event "considered to be outside the range of usual human experience." Some examples might include natural disasters (earthquakes, hurricanes, tsunamis, volcanic eruptions), or man-made (the Nazi Holocaust, the atomic bombings of Hiroshima and Nagasaki, Chernobyl and other nuclear factory explosions, horrific airplane, motor vehicle or boating crashes and accidents). In this instance, the traumatic event was the Vietnam War, and the motivation for this new diagnosis was to obtain compensation for troubled veterans of this unpopular conflict.

PTSD was a significant departure from other psychiatric diagnoses since it was not caused by some inherent defect, but rather injury due to some external catastrophic event. While much of this has been covered in previous Newsletters, some explanation is needed to explain why the diagnosis, and consequently, the treatment of PTSD, has become an increasingly tragic and costly disaster. More importantly, since no solution is in sight, the situation is far more likely to continue and worsen.

Is PTSD A Disorder, A Disease, Or Does It Simply Describe A Syndrome?

There is a tendency to believe that just because something has a name, that it has been defined, or has a meaning that everyone agrees on. With respect to medical taxonomy, classifying an illness as a disease or disorder also implies some understanding of its cause, as well as its clinical manifestations and possible consequences. Disease and disorder are often viewed as being synonymous, since they both refer to some disturbance in mental or physical function that results in illness. But for physicians, disease means there is a structural or functional disturbance in the body that can be objectively diagnosed by laboratory tests, imaging studies and/or tissue pathology. Once the cause of a disease has been identified, it can often be prevented or eradicated by appropriate treatment. This does not necessarily apply to a disorder, even when its cause or causes have been established, as is the case for PTSD. Post-traumatic stress disorder refers to a syndrome, or combination of mental and emotional symptoms or behavioral abnormalities that tend to occur in the same individual. Thus, the DSM "bible" for these is an acronym for *Diagnostic and Statistical Manual of* ***Mental Disorders, not Mental Diseases.*** Diseases can also usually be defined in one or two sentences. In contrast, PTSD now mandates fulfilling the following criteria:

A1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

A2. The person's response involved intense fear, helplessness or horror

B. Re-experiencing Symptoms (Requires one or more of) B1. Intrusive recollections B2. Distressing nightmares B3. Acting/feeling as though the events were recurring (flashbacks) B4. Psychological distress when exposed to traumatic reminders B5. Physiological reactivity when exposed to traumatic reminders

C. Avoidant/Numbing Symptoms (Requires three or more) C1. Avoidance of thoughts, feelings or conversations associated with the stressor C2. Avoidance of activities, places or people associated with the stressor C3. Inability to recall important aspects of traumatic event C4. Diminished interest in significant activities C5. Detachment from others C6. Restricted range of affect C7. Sense of foreshortened future

D. Hyperarousal Symptoms (Requires two or more) D1. Sleep problems D2. Irritability D3. Concentration problems D4. Hypervigilance D5. Exaggerated startle response

E. Duration of the disturbance is at least 1 month. Acute—when the duration of symptoms is less than 3 months Chronic—when symptoms last 3 months or longer With Delayed Onset-at least 6 months have elapsed between the traumatic event and onset of symptoms

F. Requires significant distress or functional impairment

Note that there are absolutely no objective findings that can be used to substantiate the diagnosis of PTSD. There are only symptoms that can easily be claimed and/or feigned in an attempt to obtain lifelong non-taxable compensation and free medical care.

The PTSD "Hamster Wheel"

And

Catch-22 Catastrophes

Nobody denies that such a constellation of complaints exists, or that they can result from the stress of combat and be disabling. The problem is that so many military personnel are applying for PTSD based on claims that are fraudulent or cannot be validated, there are insufficient resources to process them in a timely fashion. ***Veterans from Iraq and Afghanistan are now filing PTSD claims at an unprecedented rate of 45%.*** As a result, veterans with bona fide symptoms are unable to receive assistance, especially since noncombat related PTSD is now also compensable. According to a recent statement by the VA's Director of Benefits, "We have 4.4 million active paper records across our 56 regional offices today and these paper files are not one or two pages big, they are reams and reams and reams of paper." Some files have more than a thousand pages and all of these have to be processed by hand. A disabled veteran who handles such VA claims said he knew first-hand about this ordeal. "I put in my claim for disability and went through the systems just like all the other veterans". He explained that the brace device on his wrist was not service connected, "It's from handling all the paper."

In January 2012, the VA took an average of 188 days (over 6 months) to resolve a veteran's claim. In his Veterans Day speech, President Obama told the audience "No veteran should have to wait months or years for the benefits that you've earned, so we will continue to attack the claims backlog. We won't let up. We will not let up." But as of July 2012, 66% of claims for disability compensation and pensions were still pending more than 125 days after being filed, an increase of 60 percent over 2011. And by December 2012, the average had increased to 262 days (almost 9 months). ***According to a Dec. 17 2012 report, more than 863,000 people had pending VA compensation claims.***

Another reason for this enormous backlog is that many of the Iraq and Afghanistan veterans are listing 11 to 15 medical issues on their claims, compared to 4 or less for previous conflicts. Each complaint has to be evaluated and factored in to determine the degree of disability and amount of compensation. A master sergeant who had been riddled with shrapnel in Iraq and had a fused spine causing daily pain listed ***a total of 65 conditions ranging from numerous shrapnel wounds to PTSD.*** His claim had been submitted several months prior to his discharge on Decem-

ber 1, 2011 and he had been assured that his disability payments would start as of that date. However, seven months later, the only thing he had received from the VA was a monthly form letter stating, "We're still processing your application for compensation." The system is also overloaded because exposure to Agent Orange for Vietnam and other veterans now provides compensation for cardiovascular and Parkinson's disease, as well as diabetes, peripheral neuropathy, Lou Gehrig's disease (amyotrophic lateral sclerosis), certain birth defects in children, leukemia, and several malignancies. Evaluating and processing some 250,000 new Agent Orange claims without any increase in personnel obviously adds to this logjam.

There are also veterans like Kevin, a Marine who served three tours in Iraq and suffered from increasingly severe headaches and neck pain that made it difficult for him to retain a job. He had been rated as partially disabled when discharged, but after his condition worsened and he was unable to find any employment, he filed a new claim for an increase in his service related disability on February 2011. He waited and waited without hearing anything. His wife became so frustrated that she posted a video on YouTube last September entitled "The VA Does Not Care", complaining that when the claim was filed, "my baby was six weeks old. My child is almost 2 now ... This is getting absolutely ridiculous". Because of the increasing severity of Kevin's complaints, prompt neck surgery was necessary, which was partially covered by her employer's health insurance. By then, her video had gone viral and triggered so many sympathetic responses, that in October, the VA created its own YouTube video expressing sympathy for the Marine and veterans with similar problems. It also reassured viewers that they were now speeding things up and would provide updates on the status of claims. This led her to post another YouTube video in November, which started with "Hello everybody, I'm back." She then displayed and read a printout of the status of Kevin's claim just received, ***"Estimated claim completion date of 10-5-2013 to 5-5-2014. . . . That, right there, is why veterans commit suicide."*** Two weeks later, she suddenly received a VA ruling of 100 percent disability benefits, one to two years earlier than the last estimate. She has been unable to find out whether this had anything to do with her videos, but worries that many vets don't have someone like her to fight the VA for them. "My thing is, Kevin has me, and I'm advocating and I'm fighting for him. He gave up a long time ago."

The quandary and quagmire for veterans who appeal a rejected claim is much more serious and stressful. ***The average time between the filing of appeals and their resolution is now almost two and a half years.*** If the appeal is rejected, it can be referred to the VA's Board of Veterans Appeals, and if its decision is disputed, another appeal can be made to the U.S. Court of Appeals for Veterans Claims, an independent federal judicial panel. This appeal process can take additional months or years and can be very costly. Sometimes the court will rule in favor of the veteran, and sometimes it upholds the Board's decision, and the case is then considered closed. But it is just as likely that no final ruling will be made and the claim is referred back to the Board for further review and processing – a decision known as a remand. The case then goes to the bottom of the agenda and can remain in limbo for months or years. Some cases may be remanded

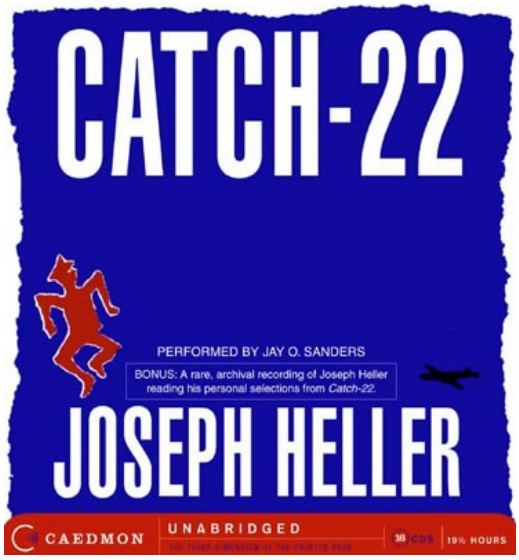
several times in a process that has been referred to as *"the hamster wheel — decision, appeal, remand, rinse, wash, repeat."*

Lawyers for an 80-year-old widow of a veteran are now asking the United States Supreme Court to empower the Court of Appeals for Veterans Claims to issue fewer remands and render more final decisions on its own to avoid such delays. ***Her case has been in the system for over four decades and is still being appealed.*** According to court documents, the Army assigned her husband to a classified remote Nevada nuclear-testing facility in 1953, where he was exposed to radiation. He later died from a form of lymphoma in 1971 at age 42 and she applied for a death pension and other benefits provided to widows of veterans. She subsequently submitted evidence from doctors stating that her husband's cancer was due to the radiation he was exposed to while in the Army. After repeated rejections and appeals, the Board of Veterans Appeals in 2009 granted part of her claim and set an effective date of 1988 – entitling her to a retroactive payment for benefits starting from that date. She and her lawyers argued that the correct date should be 1971, when her husband died, and appealed to the Court of Appeals for Veterans Claims. Last year, the Court agreed that the Board had probably erred on the effective date, but rather than making this ruling, remanded it back to the Board "because that would require it to make factual determinations in the first instance based on the evidence the Board failed to consider, which it may not do." She appealed this ruling to the United States Court of Appeals for the Federal Circuit, but lost and is now seeking relief from the Supreme Court. Whether or not they decide to hear this case will not be determined until some time later this year.

Several veterans groups and prominent lawyers have filed supportive briefs, one of which argued that when Congress created the Court of Appeals for Veterans Claims in 1988, they wanted it to be an independent body with the expertise not only to uphold or overrule the Board of Veterans Appeals, ***but also "to make judgments on the merits of a case".*** VA lawyers maintain that, like most Federal Appeals Courts, it does not have the authority to review the record and make decisions on the facts of a case. "The Veterans Court is authorized by statute to 'affirm, modify, or reverse a decision of the Board or to remand the matter, as appropriate.'" In a blog commenting on this matter, the daughter of the two individuals involved wrote, "If you go by the official VA record as it now exists, you will not get the whole story. Files have been conveniently lost, burned, etc, etc. And most of the people who have any connection to the story are long gone. The VA counts on the vet and their spouse to check out and then there is no longer a case. What the VA is not counting on is an 80-year-old woman who will not quit and should have been a lawyer. I do not know if she will prevail but you must agree that 40 years is too long. The VA or Supreme Court can stop the hamster wheel. That is what my Mom is requesting."

"Catch-22" glitches are another obstacle that veterans with PTSD symp-

toms encounter. This term was coined by Joseph Heller in his 1951 novel *Catch -22* to describe the "you can't win" policies WWII troops experienced with military bureaucracy. Catch-22 is now used to describe any paradoxical situation in which it is impossible avoid a problem due to inherent contradictory regulations or conditions, so that you are "damned if you do and damned if you don't." One example cited in the book was an Air Force bombardier who wanted to be excused from dangerous combat missions. This would require him to have been found to be "mentally unfit to fly" by the squadron's flight surgeon. But the Army apparently reasoned that you would have to be crazy to ask or agree to serve on a mission with a high risk for death. Thus, anyone requesting a mental fitness examination for such an exemption must be sane. And since a mental evaluation will not be performed unless requested, even if clinically insane, the individual cannot be found to be "mentally unfit" and must also fly in combat missions.



The Catch-22 for troops with PTSD symptoms is the stigma attached to this diagnosis that prevents finding employment when they become civilians. In one case, a decorated Army sergeant had passed the NYPD entrance exam six months after his honorable discharge in 2006. Although he later graduated magna cum laude from the John Jay College of Criminal Justice, his application was rejected because his military record suggested a history of PTSD. It revealed that his Humvee vehicle had been shelled six times during his tour in Iraq. As he explained, "Getting blown up by IEDs is scary. Once in a while, I got a little uncomfortable. In large, disorderly crowds I was a little hypervigilant, which could be viewed as a good thing." He had admitted these occasional symptoms during his annual physical exam and the Army shared this information with the NYPD. Although three psychiatrists certified he did not have PTSD or any other mental or emotional problems, he was still branded as being psychologically unfit and was disqualified from serving on the police force.

He subsequently went through an inheritance from his grandfather in a futile attempt to appeal the Civil Service Commission's ruling. Medical experts again testified he no longer had any PTSD symptoms to no avail, and he finally gave up. As he told one reporter, "It was a long, complicated process and they didn't know how to clear my record because people don't usually ask the Army for less benefits — they ask for more. They taught me to have integrity in the Army and be honest, and look where it got me. I'll never realize my childhood dream of joining the NYPD." Many other veterans have been faced with this Catch-22 dilemma. They are constantly urged to seek help for any mental or emotional complaints, but if they disclose they have had PTSD symptoms, they may be disqualified for police, fire and other Civil Service positions. And if they conceal their complaints from the military and prospective employers who can gain access to their medical records, they run the risk of being denied health care if their condition worsens.

Should The Term PTSD Be Abandoned?

What Are The Alternatives?

As previously indicated, PTSD is not a disorder that can be validated by any objective criteria. It is simply a syndrome, or set of symptoms that often occur in the same individual. These may or may not be concurrent or related, can have different causes, and therefore require different treatments. In some patients, attempts to relieve certain PTSD symptoms can worsen others, or serious adverse side effects from trial and error drugs or shotgun therapies that attempt to treat all complaints far outweigh any benefits. Affected service personnel, especially those who are career oriented, are reluctant to seek assistance, since being labeled with this diagnosis would probably hinder any chance for promotion. A spokeswoman for the Department of Defense who denied this said, "Seeking help is a sign of strength not weakness . . . . No, military careers aren't at risk for seeking help. . . . Many service members with symptoms of PTSD recover with appropriate medication and/or psycho-therapy within a few months." To support this, she cited this May 10, 2012 memorandum from Secretary of Defense Leon Panetta, **"Leaders throughout the chain of command must actively promote a constructive command climate that encourages individuals to reach out for help when needed."**

That message is not getting through to lower command echelons and troops. The reverse is more apt to be true. As one veteran recently explained, "Soldiers are encouraged by lower-level leadership and their peers not to get help because of the stigma. If you go to get help, you'll be chastised by your peers." See video .

Many wait until they retire to seek assistance for their mental health problems because the military does not guarantee medical confidentiality in contrast to civilian physicians. In addition, the majority of individuals exposed to combat trauma recover without any treatment. Most service related PTSD tends to surface after retirement in veterans having difficulty finding jobs and coping with civilian life. **Having a "disorder" implies that you have a condition that is permanent.** General Peter Chiarelli, former Vice-Chief of Staff of the Army, also complained, "No 19-year-old kid wants to be told he's got a disorder. I drop the D. That word is a dirty word. PTSD suggests the ailment is 'pre-existing', when in reality, it is a predictable reaction to combat stress."

He recommended simply calling it PTS (Post Traumatic Stress) and urged the American Psychiatric Association to make this change in DSM-5, which will be available in a few months. PTS was also agreed upon and adopted by officials at the highest Pentagon levels, including Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff and Defense Secretary Leon Panetta. Nevertheless, no changes will be made because of vehement objections from drug companies and others who fear that the government, as well as insurance companies, will not pay for anything not considered to be a disease, disorder or injury. Billions of dollars are at stake. The Canadian armed forces have for over a decade referred to this as OSI (Operational Stress Injury) to avoid this problem. PTSI (Post Traumatic Stress Injury) has been proposed to replace PTSD, but powerful vested interests have also rejected this because injury does not imply a permanent disability that requires lifelong treatment. The same holds true for PTSS (Post Traumatic Stress Syndrome). See George Carlin on PTSD euphemisms below.

Video location in online version

As Shakespeare's Juliet complained,

'Tis but thy name that is my enemy.
Thou art thyself, though not a Montague.
What's Montague? it is nor hand, nor foot,
Nor arm, nor face, nor any other part
Belonging to a man. O, be some other name!
What's in a name? That which we call a rose
By any other name would smell as sweet.
Romeo and Juliet (II, ii, 1-2)

"A Pox On You"

...And Syphilis

People are usually named by their parents, but there are no rules or regulations for illnesses. Some diseases are named after the individual who first described them (Addison's, Cushing's, Parkinson's, Alzheimer's), a prominent patient (Lou Gehrig's, Hartnup's), a geographical area (Lyme, Bornholm), or even an organization (Legionnaire's). Some have their origin in a foreign language, such as cancer (Latin for crab), diabetes (Greek for siphon), leprosy (Greek for scaly, mangy), or *takotsubo* cardiomyopathy, (Japanese for octopus trap). Others, like sleeping sickness, whooping cough and muscular dystrophy are named for some symptom or sign. Mumps is Old English for lumps or bumps in the cheeks and measles comes from *masel*, a medieval Dutch word meaning "blemish". A pox was any disease whose major sign was marks, pits or depressed scars in the skin called "pocks" or "pockmarks". Pock was an Old English word for an eruptive pustule, and the blemishes from these were characteristic for chickenpox, cowpox and smallpox. If not specified, they were considered to be from the "great pox" or syphilis. " A pox on you" means, "I hope you get syphilis". Other diseases like plumbism or lead poisoning also got their names from their suspected sources and many, like PTSD, have had multiple names.

Syphilis is a good example. It comes from a 1530 poem written in Latin by the Italian physician Girolamo Fracastoro titled *Syphilis Sive Morbus Gallicus* ("Syphilis or The French Disease"). The poem portrays Syphilis, a shepherd, as the first man to contract the disease as a punishment from the god Apollo for being disrespectful. In 1494, King Charles VIII of France invaded Italy, but his army collapsed after a few months because of a mysterious new disease spread by sexual contact with local prostitutes that was fatal for many or left survivors weak and disfigured. French soldiers also carried the disease to Germany and Poland, then spread into Africa and Asia, where it was also referred to as the "French disease." The Dutch called it the "Spanish disease", the Russians called it the "Polish disease", the Turks called it the "Christian disease", and the Tahitians called it the "British disease". Forensic scientists have developed new ways to identify syphilitic lesions in ancient bones believe Columbus's sailors brought the disease to Europe from the New World. Columbus himself died from late stage syphilis. European bones prior to 1492 have few syphilitic lesions in contrast to bones after that date. However such lesions have been found in bones from North and Central America that date back thousands of years.

Syphilitic Man Albrecht Dürer, 1484

The signs and symptoms of syphilis vary depending on which of the four stages surfaces. The primary stage presents with a single chancre (a painless on-itchy ulceration) a week or two after contact, usually on the penis in men and cervix in women. The second stage occurs 4-10 weeks later as a papular or pustular non-itchy rash on the trunk and extremities, including the palms and soles. Albrecht Dürer's 1484 engraving to the left is believed to be the first illustration of this. As can be seen, it was thought to have an astrological cause rather than a punishment from Apollo. There may also be infectious, wart-like lesions called condylomata on mucous membranes, as well as fever and other systemic symptoms. These usually resolve after a month or so, following which there is a latent period lasting up to two years during which there are no symptoms although the disease is still present. Tertiary syphilis begins 3-15 years after the initial infection and may present as soft, tumor-like balls containing necrotic tissue called gummas. These vary in size and location but are often found in bone, brain, skin, and liver. Neurosyphilis may be manifested by tabes dorsalis (loss of balance, and shooting pains in the legs), paralysis, mental derangement and a form of dementia called general paresis of the insane. This has essentially disappeared since the advent of penicillin. Syphilis has also been called "Cupid's disease" and lues, or *lues venera* (Latin for venereal plague). Due to its frequent varied and atypical presentations, syphilis was so often

confused with other diseases and mental disorders, that it was labeled "the great imitator" or "the great pretender". No blood or other diagnostic tests were available until the early twentieth century, after its cause was discovered to be a corkscrew bacterium or spirochete (*Treponema pallidum*). Many neurosyphilitic patients with mental abnormalities were thought to be suffering from manic-depressive psychosis (bipolar disorder), hysteria, melancholia (depression), dementia praecox (schizophrenia), or even demonic possession – and treated accordingly.

As with PTSD, treatment depended entirely on signs and symptoms. Mercury was the treatment of choice and fever therapy was also popular, particularly by making patients contract malaria, which could be successfully treated with quinine. This was such an important advance in the treatment of neurosyphilis that Julius Wagner-Jauregg was awarded the 1927 Nobel Prize in Medicine "for his discovery of the therapeutic value of malaria inoculation in the treatment of dementia paralytica". Neurosyphilis was so dreaded and disabling, that even after penicillin became available, it was prescribed along with malaria induced fevers, often over a three-year period.

Like PTSD, syphilis is also pejorative and derogatory since it suggests a lack of emotional and behavioral stability. The Dutch, which had a long colonial rivalry with Spain, called syphilis the "Spanish disease" to imply that Spaniards were immoral or dishonorable. Similarly, many famous historical figures, including Charles VIII of France, Hernán Cortés of Spain, Ivan the Terrible, Benito Mussolini and Adolf Hitler were alleged to have syphilitic dementia in "whispering" campaigns designed to discredit them. We do know that Hitler contracted syphilis from a Jewish prostitute in Vienna in 1908 that probably progressed to neurosyphilis. According to one psychiatrist, this "fueled the deadly logic and blueprint for the Holocaust". Hitler devoted 13 pages to syphilis in *Mein Kampf,* in which he wrote, "The job of combating syphilis, the Jewish disease, should be the task of the entire German nation. The health of the nation will be regained only by eliminating the Jews." His bizarre belief that syphilis was a hereditary disease originated and propagated by the Jews that caused insanity and mental retardation was also the reason he tried to eliminate anyone that was mentally hampered, including homosexuals and others who were considered degenerates. Under his edict, called *Aktion T4*, 400,000 people were sterilized against their will and over 70,000 were executed.

His personal physician Dr. Theodor Morrell, was known to specialize in the treatment of syphilis and to advocate unorthodox therapies. He kept a diary of Hitler's symptoms and what he prescribed for various complaints, such as severe gastric crises, skin lesions, violent mood swings and Parkinsonian like tremors that tended to confirm he had syphilis. His subsequent "sudden criminal behavior, paranoia, mania and grandiosity" were also consistent with neurosyphilis. At the time off his death by suicide in April 1945, Hitler was taking 28 different pills a day, along with injections of glucose with nutrients every few hours, as well as an intravenous drip containing methamphetamine, a psychostimulant

that induces mania with accompanying euphoria, feelings of self-esteem and increased libido.

The treatment of syphilis often made patients worse because of serious side effects and toxicity that could be fatal. The composer Franz Schubert contracted the disease in 1823 at age 21, subsequently developed the typical signs and symptoms of secondary syphilis and later severe mood swings that varied from being manic or extremely angry to deep depression. He was admitted to a Vienna Hospital where he received mercury (quicksilver) therapy, and was placed under the care of Dr. Joseph von Vering, the author of two books on the subject. Mercury was mixed with lard and vigorously rubbed into the torso and extremities in a confined heated room with no ventilation to promote vaporization. Some mercury reached the blood stream through the skin but inhaled mercury vapor had a more rapid and robust effect. Mercurial compounds were also given by mouth. Controlling the dosage was difficult since absorption varied with each patient and many developed toxic effects that could be lethal. Unfortunately, signs and symptoms of mercury poisoning such as impaired vision, hearing, memory, coordination as well as peripheral neuropathy were also seen in neurosyphilis, which often led to more aggressive treatment. Schubert even told friends that he felt like he was being poisoned and would never get better. He died at age 31 from what most authorities now feel was mercury poisoning. Robert Schumann, another composer, also contracted syphilis when he was 21 and later received mercury therapy. He followed a similar course before dying at age 46, but evidence it was due to mercury poisoning is not as strong and syphilis was the more likely cause of death.

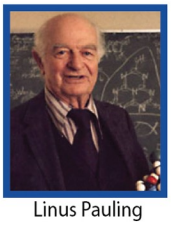
Ludwig von Beethoven's progressive deafness that started at age 27 was attributed to syphilis since it was known that he associated with prostitutes and had received mercury salve treatment. When he died three decades later, an autopsy found changes consistent with syphilitic meningitis but the cause of death was listed as "abdominal dropsy". This is an archaic term for an excess accumulation of fluid in the abdomen now referred to as ascites. This was undoubtedly due to extensive cirrhosis of the liver resulting from his heavy intake of alcohol. However, studies conducted over the past decade now suggest that he may have died from lead poisoning. During his last months, physicians performed repeated operations to relieve his ascites. He was often semi-comatose during this period and visitors clipped locks of his hair to remember him. Some that have been preserved and subjected to spectrographic analysis show high concentrations of lead consistent with lead poisoning. On four occasions, when between 2 and 3.5 gallons of abdominal fluid were removed, the concentration of lead spiked following each procedure. This was likely due to the large amount of lead salts used to cleanse the wound and prevent infection. Another contributor may have been the Danube fish he was fond of, since these were later found to have a high lead content. He also consumed large amounts of wine that were stored in a lead crystal decanter and used lead crystal wine glasses.

GET INSIDE OUR HEAD

It's Not Our Credentials That Make AIS So Impressive, It's the Fellows That Go with Them.

The American Institute of Stress is a non-profit organization established in 1978 at the request of Dr. Hans Selye (the Founder of the Stress Concept) to serve as a clearinghouse for information on all stress related subjects. AIS Founding Fellows include:


Paul Rosch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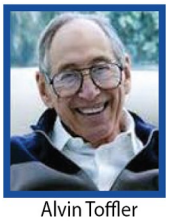
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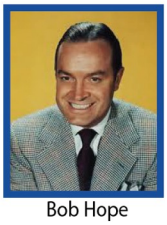
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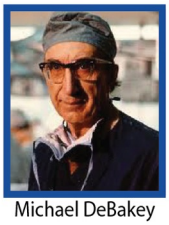
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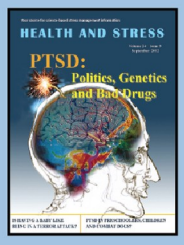

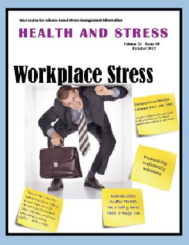

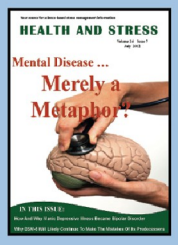

We are offering sample issues of our newsletter, *Health and Stress*, covering the topics of:

1. PTSD: Politics, Genetics and Bad Drugs
2. Workplace Stress: Exclusive Interview with Lennart Levi, MD, PhD
3. Is Mental Disease Real or a Metaphor?

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Why PTSD Got Its Name And Its Treatment May be Causing Suicides

The point of all the above is to emphasize that **the treatment of a disorder often makes the patient worse. PTSD may be the epitome of this.** As Paracelsus noted 500 years ago, "All things are poisons, for there is nothing without poisonous qualities. It is only the dose which makes a thing poison." That was true for syphilis before penicillin became available, but the problem is different for PTSD because it is a syndrome, not a disease or a disorder. This was recognized from the very beginning, since **its original name, Post-Vietnam Syndrome**, was coined by Chaim Shatan, a New York psychiatrist. In his May 6, 1972 Op-Ed *New York Time*s article, he described this syndrome as "delayed massive trauma" characterized by guilt, rage, the feeling of being scapegoated, psychic numbing and alienation that occurred 9 to 30 months **after combat**. Dr. Eugene M. Caffey, VA Deputy Director of Mental Health reiterated the Agency's view that Post Vietnam Syndrome (PVS) was little more than a phony issue dreamed up by VA critics, and that "A lot of this is rooted in these people's antiwar feelings. . . . **It's a frame of mind which is disturbing to them and it affects no more than 5 percent of the veterans**." Something similar had been called "shell shock" in World War I to describe this **response to combat**, but interest in this waned until World War II when soldiers **exposed to severe or chronic combat** experienced a **syndrome** characterized by anxiety, intense autonomic arousal, reliving, and sensitivity to stimuli similar to the original trauma. This syndrome was given several names, including traumatic war neurosis, **combat fatigue**, and **battle stress.**

It was subsequently recognized that a similar syndrome could occur in civilians exposed to catastrophic events, and when DSM-I appeared in 1952, it included the diagnosis of gross stress reaction. **It was defined as a "stress syndrome"** that is a response to an exceptional physical or mental stress, such as a natural catastrophe or battle; it occurs in people who are otherwise normal; and **it must subside in days to weeks; if it persists, another diagnosis should be made.** However, in the revision of this in DSM-II published in 1968, this diagnosis was omitted with no explanation. As a result, **no official diagnosis for stress disorders was available between 1968 and 1980**, when DSM-III was published. The Tet Offensive, in which surprise strikes were made at the Ameri-

can base at Danang and the American embassy in Saigon also occurred in 1968. The war didn't end until 1973 when the South Vietnamese government fell and it took another few years to arrange for U.S. troops to withdraw. Thus, the conflict was very much on the minds of the DSM-III Task Force who had to decide whether the diagnosis of gross stress reaction should be reinstated or replaced by one incorporating the research findings that had accumulated over 22 years. They chose the latter, and as one member explained:

> The stressor was defined relatively narrowly: as so severe that it would produce significant symptoms in almost anyone, as outside the range of normal human experience. It could be physical or psychological or both. **In recognition that a stress syndrome is a final common pathway with many entry points reflecting the variety of stressors that can produce it, there was no specific "post-Vietnam syndrome."** Instead the new diagnosis was given the very general name of "posttraumatic stress disorder." For the stressed, there was no requirement of preexisting normality; this decision was based on the recognition that individuals vary in vulnerability and resilience. The symptoms were divided into three general categories: reexperiencing (including dissociative-like states), numbing of responsiveness, and cognitive or autonomic symptoms. The onset could be either acute or delayed.

The current DSM-IV published in 1994 lowered the bar further and made it possible for almost anyone in the armed forces to file a claim for disability due to PTSD. The DSM-IV-TR revision of 2000 did nothing to address this and it seems likely that no significant changes will be made in DSM-5. As highlighted above, up until 1980, PTSD was considered to be **a syndrome caused by the stress of combat or some other catastrophic event**. Its subsequent designation as a disorder has no medical basis, but allows pharmaceutical companies and others to reap huge profits from products and services that have not been demonstrated to provide benefits, and this has now been extended to individuals who have not experienced either combat stress or a catastrophic event. This could have enormous financial consequences since DSM is also used by courts, social services agencies, governments, policy makers, prisons, drug regulation agencies and others to determine mental health diagnoses that can influence awards and compensation. Sales of DSM-5 in the U.S. are conservatively estimated to bring in over a million dollars a year, but several times that are now anticipated from translations in foreign languages, tapes, videos, study guides etc. Of particular concern are claims that **the vast majority of DSM panel members have strong financial links to drug companies**, many of which are not disclosed. For the panel dealing with depression, it is 100 percent. The way to sell drugs is to sell mental illness, and the number of new diagnoses has steadily increased with each edition. Dr. Allen Frances, Chairman of the DSM-IV task force, was so appalled at some of the proposed new diagnoses, that he urged

everyone to ignore DSM-5.

> We have failed, and DSM-5 has failed us. For reasons that I can't begin to fathom, DSM-5 has decided to proceed on its mindless and irresponsible course. The sad result will be the mislabeling of potentially millions of people with a fake mental disorder that is unsupported by science and flies in the face of common sense.

Drug company pressure was not mentioned, but consider the following:

> You can't treat a syndrome with a drug. Saint's Triad is a syndrome consisting of gallstones, hiatus hernia and diverticulosis. Drugs given for any one of these will not benefit the others, nor will surgery. But if you call this a disorder, it might require lifelong drug therapy.

Although we are withdrawing from Afghanistan and the war in Iraq is over, 45% of all troops from these conflicts are now filing PTSD disability claims. **the majority of which are not combat related**.

Drugs are first-line treatment and are administered to almost all PTSD patients. Zoloft and Paxil are the only two drugs that are approved for treating PTSD, but since these are ineffective in up to 90% of cases, others are prescribed off-label. It is estimated that **it costs $10,000/year to treat each PTSD soldier at a price tag of at least $5 billion annually.**

Despite such drug cocktails, over four out of five patients are not only no better after taking them, but most are worse because of serious side effects that can be lethal. They may also be responsible for what Defense Secretary Leon Panetta and others have called an "epidemic of military suicides."

Suicides among U.S. soldiers rose 80 percent from 2004 to 2008 and have continued to escalate since then. They reached a record high of 349 in 2012, an increase of 48 over 2011. **This does not include 110 pending reported suicides in active duty troops or those who died from drugs that were classified as accidents.** As illustrated in a previous Newsletter,

> A 26-year-old corporal who was found dead in his room at the National Naval Medical Center had at least nine prescription drugs to improve sleep, relieve pain and reduce anxiety in his system. A 23-year-old MP died in his apartment five months after being discharged. Eight drugs were found in his blood, including a sedative, a sleeping pill, two potent painkillers and three antidepressants. The medical examiner concluded it was an accident, not a suicide. A Marine gunnery sergeant was started on drugs for depression, anxiety and Klonopin, an antipsychotic, for his PTSD complaints. Opiates were later added to relieve back pain. He was found dead in his on-base quarters in North Carolina. An autopsy revealed two antidepressants, two powerful nar-

cotics and an anti-anxiety drug in his system and 30 bottles of pills were found, most of them recently prescribed. He had called his wife in Ohio a few days previously and told her he was tired, but "I don't think I'll have any trouble falling asleep tonight." She said he sounded delusional but not suicidal and the pathologist agreed. The official report stated death was "most likely due to the interaction of medications". He was 38 and had spent 19 years in the military. See more

PTSD patients are 6 times more apt to commit suicide, but we don't know how many veterans or active duty troops have attempted to kill themselves and failed. **22 veterans commit suicide every day and the VA's national veterans' suicide crisis line averages 17,000 calls daily**. However, active duty personnel are unlikely to ask for help, not only for the reasons previously cited, but also the possibility of a court-martial.

Lazzaric Caldwell, a 23-year-old Marine who had never been in a war zone was diagnosed in 2009 with post-traumatic stress disorder and treated with Zoloft, an antidepressant. Despite regular psychiatric visits his condition worsened, he suffered a convulsion, and in 2010 attempted suicide by slashing his wrists. As a result, he was put in the brig for a month and later pleaded guilty to and was convicted at a court-martial for "intentional self-injury without intent to avoid service." He was sentenced to 180 days in jail and received a bad conduct discharge, which made him ineligible to receive any service benefits. Had he been successful, he would have been treated as if he had been killed in combat. The surviving family member would receive the same condolence letter from the President, a non-taxable $100,000 death gratuity his spouse would be awarded a $1,154 monthly annuity, a $286 monthly allowance for each dependent child under 18, government life insurance of up to $400,000, free medical care, housing and education assistance, social security and other financial aid. Total payouts average $1,185,000 but can be up to $4.7 million. New York and other states provide additional stipends.

Despite the lack of any medical testimony Caldwell's appeal last December was rejected and his attorney has now asked the military's highest court, the U.S. Court of Appeals for the Armed Forces in Washington, to hear the case. The government had claimed that Caldwell "was not charged with, or convicted of, attempting suicide. He was charged with, and properly convicted of, intentionally injuring himself to the prejudice of good order and discipline or the discredit of the service." His lawyer argued that military law prohibits intentional self-injury prosecutions for suicide attempts induced by depression, PTSD or other mental illness but there should be a presumption such clients can't form a guilty intent. Successful suicides are presumed to have been committed in the line of duty and the member's death isn't considered to have been due to their own misconduct. You can decide for yourself by listening to **Caldwell's poignant explanation here.**

Drug Companies Ignore Hippocrates'

Primum Nil Nocere,

First, Do No Harm

Caldwell received Zoloft, which was approved for treating PTSD in 1999 **based on two 12-week studies with no long-term follow-up.** Paxil was approved in 2001 as the only drug to treat all three major PTSD symptoms (Feeling numb, hypervigilance and avoiding things reminiscent of the traumatic event or having flashbacks of it.) **Both are banned in the U.K. and elsewhere for anyone under 18 because they have been shown to increase suicidal tendencies**. The FDA has mandated that they carry a Black Box warning label not only for children, but also the 18-24 age group, which has the highest rate of military suicides. Veterans now account for 20% of suicides in the U.S., with **those 24 and under taking their lives at four times the rate of other veteran age groups.** That antidepressants are not significantly more effective than placebos, have numerous adverse side effects and are addictive was again reiterated two weeks ago in the *British Medical Journal*. Click here and here. Not mentioned in this synopsis and reply was the likelihood that these drugs are responsible for a 64% increase in violent sex crimes, (including military sexual assault on female and male personnel by other military personnel), a rise of 33% in domestic violence and 43% in child abuse. Almost half of patients complain of loss of libido, so it is no surprise that the VA spent over $72 million on Viagra, Cialis and Levitra last year, almost triple the amount spent in 2006. The fact that these antidepressants continue to be prescribed for almost all PTSD patients illustrates the powerful influence and control drug companies have over the FDA, other regulatory authorities, academia, medical journals and the media. They also gain approval for their products by support from prominent authorities on their payroll that are listed as authors on papers they have not contributed to, and which are deliberately deceptive.

Last summer, GlaxoSmithKline (GSK) agreed to plead guilty and **pay $3 billion to resolve criminal and civil charges** in connection with off-label promotion of several drugs, failing to report safety data and filing false prices. It was the largest drug company settlement ever and concentrated on a " misleading medical journal article" claiming that Paxil was effective in treating patients younger than 18, when it was clear that this was false. It was based on a study that was cited by New York's Attorney General in his 2004 lawsuit charging GSK with "repeated and persistent fraud" by promoting positive findings but concealing unfavorable data. The saga began in 2001, when the J*ournal of the American Academy of Child and Adolescent Psychiatry* published a paper concluding that Paxil was "generally well tolerated and effective for major depression in adolescents" co-authored by 20 authorities, headed by Dr. Martin Keller, Professor of

Psychiatry at Brown University. Internal documents obtained during the Federal probe revealed that Paxil (paroxetine) was no more effective than placebo in one study conducted here, and in others carried out in Europe and South America, placebo was actually more effective. One memo advised that any positive data "will be published in abstract form at the European College of Neuropsychopharmacology meeting" in November 1998, and that "It would be commercially unacceptable to include a statement that efficacy had not been demonstrated, as this would undermine the profile of paroxetin."

GSK contracted in April 1998 with Scientific Therapeutics Information, (STI) to prepare an article for journal publication and they wrote the paper and later did revisions with minimal input from the supposed scientific authors. As part of the laundering process, STI downplayed the primary endpoints and substituted 8 "efficacy measures," none of which had been specified in the original study. And by manipulating the data, STI could show that Paxil was statistically better than placebo on 4 of the 8 newly invented measures. The purported authors sent the paper to the *Journal of the American Medical Association* in December 1999, claiming that Paxil was "a safe and effective treatment for major depression in adolescents." It was rejected since the reviewers realized there was no solid supportive data, and another memo indicated that GSK and Dr. Keller decided to send the manuscript to "a less demanding journal", such as the *Journal of the American Academy of Child and Adolescent Psychiatry.* They also rejected it for similar reasons in June 2000, and GSK asked STI to revise the paper so that it responded to the reviewer's criticisms. This new revision of the paper was finally accepted by the journal in February 2001, although it still included incorrect and misleading statements, like Paxil "is generally well tolerated and effective for major depression in adolescents". More importantly, the 11 patients with serious adverse reactions due to Paxil, and the 5 of them with specifically suicidal or agitated symptoms magically disappeared. When the FDA obtained and analyzed the raw data, it found that 10 of 93 patients taking Paxil had experienced a potentially suicidal reaction, which was much more alarming than the minimal risk portrayed in the paper - a far different and more alarming picture than that portrayed in any of the drafts or in the final manuscript.

To make certain child psychiatrists were unaware of this, GSK conducted meetings at lavish resorts in Hawaii and Palm Springs and psychiatrists who attended had their airfare and hotel paid plus a $750 honorarium, and in many cases their spouses were also reimbursed. The hired speakers who lauded how wonderful Paxil was for treating yougsters received an additional $2,500. To give you some idea of the extent of this marketing campaign, GSK had enrolled 49,000 health professionals in its speakers' bureau for Paxil and other drugs. The STI ghostwriter admitted in her deposition that 5.4% of the Paxil children tried to kill themselves vs. 0% for those on placebos, and that "The published paper does not specify the number or percent of patients who attempted suicide." She testified that she wrote the first draft entirely on her own, had no communication with any of the authors listed on the paper before writing the article, and after sending Dr. Keller the first draft, could only recall communicating with him and possibly 4 of the other 20 authors. Although the published paper was obviously fabricated, the journal repeatedly refused to issue a retraction or any statement acknowledging this even after GSK admitted this. Brown University also declined to disavow it, but after two decades of leading their Department of Psychiatry and Human Behavior and receiving numerous commendations, Dr. Keller abruptly resigned the day before the settlement was made public. No explanation was offered for this or its timing.

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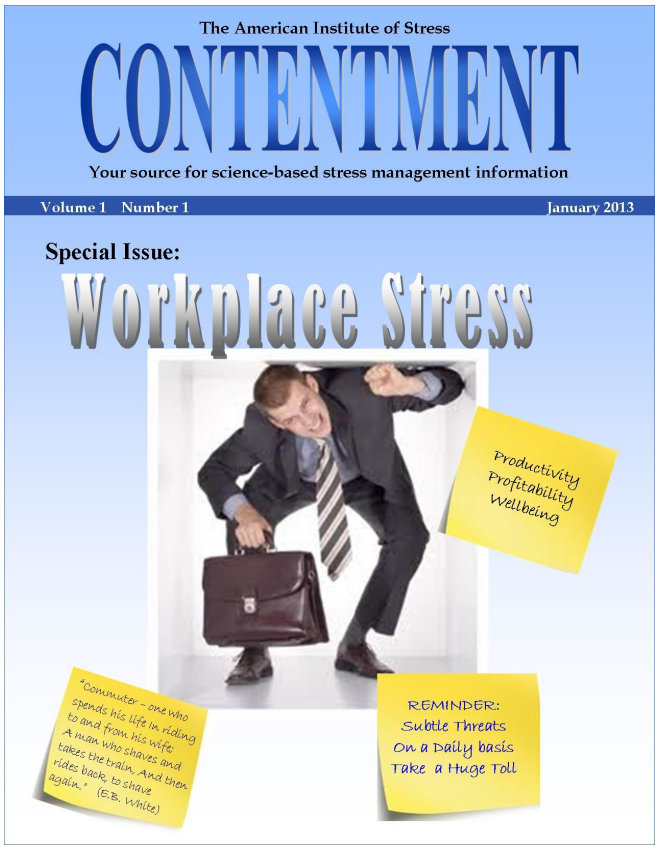
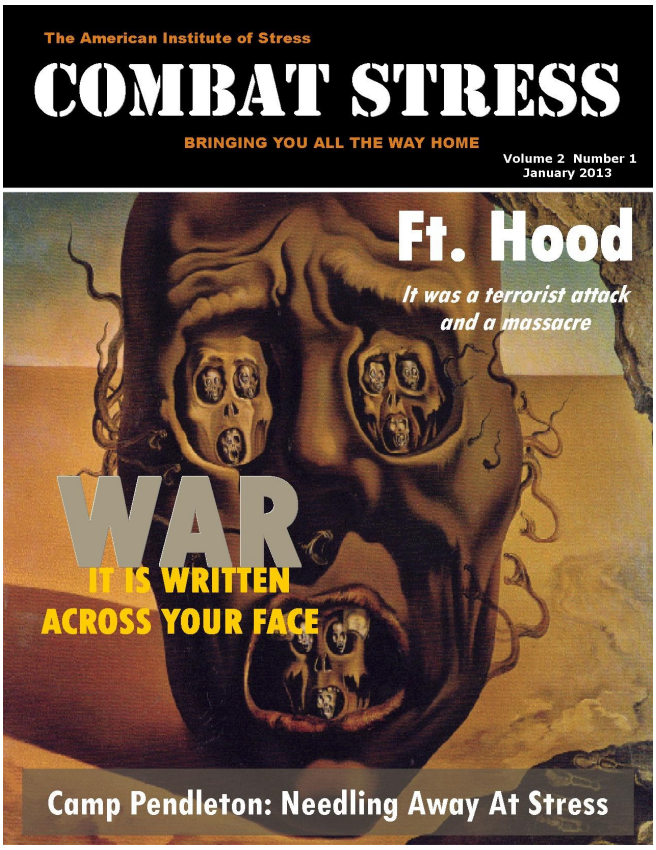




CLICK IMAGES TO READ THEM NOW

Is There Any Hope For The Future Or Will Drugs Continue To Prevail?

It should be obvious from this newsletter that pharmaceutical companies will do anything to perpetuate their prodigious profits and that they have the power to preserve the status quo. But there is some light at the end of the tunnel, since eventually, as Shakespeare also wrote, "truth will out" and the fallacy of our current approach will become apparent to all. That has already begun thanks to four-star General Peter Chiarelli, who retired in 2012 as Vice Chief of Staff of the Army. His more than forty years of service career included two combat tours in Iraq, both of which came during periods when the insurgents appeared to be gaining strength and U.S. casualties were mounting. He became particularly concerned with the rising rates of PTSD and suicides and during his last four-year assignment as the 2nd highest ranking Army officer on active duty, this became his major focus. He spearheaded efforts to reduce these and especially to remove the stigma and damage of being labeled with PTSD, arguing that it was not a lifelong disorder and the D should be dropped. This also applied to civilian diagnoses such as victims of sexual assault, asking " "Is it right to tell a woman who's been raped that because she has a reaction to that, that she has a 'disorder'?" He established a monthly video teleconference to meet with commanders around the world to discuss the details of recent suicides in an attempt to identify trends and missed opportunities in which intervention might have been effective. The two-hour conferences were described by some as "gut -wrenching", and he reviewed every single suicide.

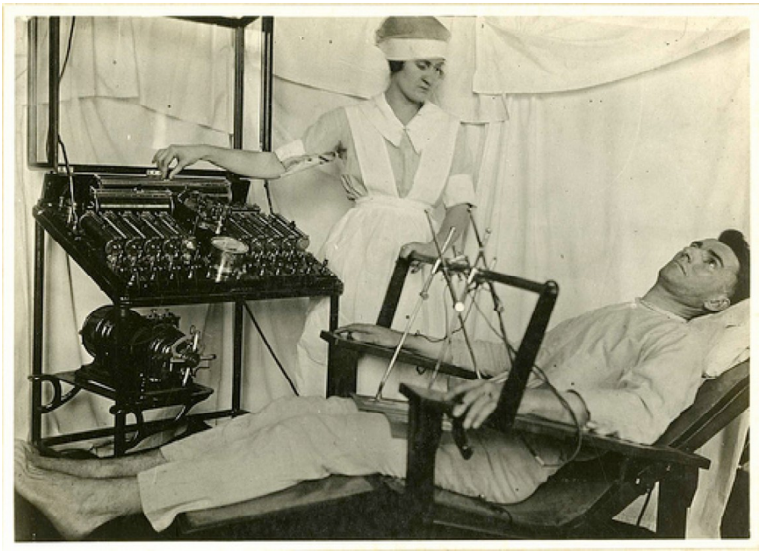
He also asked PTSD patients about how they felt and whether their treatment was working, and told one reporter, "Soldiers would tell me point blank that the doctor talks to me for five minutes and throws a bag of pills at me." When he talked to doctors, he was appalled at how they rarely agreed on how to diagnose PTSD. This became apparent last summer, when it was disclosed that therapists at Madigan Army Medical Center in Washington State had reversed over 40% of PTSD diagnoses for hundreds of patients being considered for medical retirement since 2007. An ombudsman investigated complaints that the forensic psychiatric team had diagnosed some of them as "possible malingerers." He also wrote a memo about a lecture one of them had given about the need to consider costs and not rubber stamp a PTSD diagnosis that could result in a soldier earning $1.5 million in benefits over a lifetime. Defense Secretary Leon E. Panetta asked Chiarelli to retire from the Army and serve as Undersecretary of Defense for Personnel and Readiness, one of the Pentagon’s top senior civilian positions. This would have allowed him to remain involved in mental-

health issues, but he turned it down to become CEO of One Mind For Research, a new-model non-profit dedicated to delivering accelerated new treatments and cures for all brain illness and injury. Its major focus is on how to develop a biomarker to establish a diagnosis of post traumatic stress, or post traumatic stress injury. This will likely come from brain imaging studies, but if you do nothing else, listen to him explain this in his own words, as he describes his epiphany here.

Video location in online version

You can learn more about One Mind For Research here.

Finding a biomarker for PTSD that improved diagnostic accuracy would undoubtedly lead to new and better therapies, which I suspect will likely focus on influencing communication in the brain by subtle energies rather than pharmaceuticals. Electroconvulsive shock therapy is still the most effective treatment for severe depression, and although it has been in use for 80 years, we still do not know why it works. We do know that it is safer and more effective than insulin coma and metrazol induced convulsions. So called "electromedicine" has a bad reputation because it has long been associated with quackery. The 1910 Flexner report correctly stated that there was no scientific basis for any of the types of electromedical" devices that continue to make unsupported claims. However, times have changed, and great strides have been made, as illustrated by the evidence based devices and approaches we identified in *Bioelectromagnetic Medicine*. This is now under revision to include numerous advances in the last decade. A electrotherapy Bergonic chair " shown below was used in World War I to treat what were referred to as "psychoneurotic" complaints. It was apparently more beneficial and safer than drugs that were available at the time, although these may have been placebo effects.



Spurious and worthless copycat devices still abound, but it is important not to throw the baby out with the bathwater. In that regard, as emphasized in previous newsletters, cranial electrotherapy (CES) is FDA cleared for treating depression, insomnia, anxiety and pain, common complaints in PTSD. Unlike the above and other devices, double blind studies confirm that these are not placebo effects. CES is much safer and more effective than drugs, is not addictive, and is preferred by 75% of veterans over other non-drug therapies. Its wider use has been thwarted by drug companies and others with vested interests, but military sales are steadily increasing. Hopefully, "the truth will out",— so Stay Tuned!!

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